



**For new referrals, please include recent labs and last two office visit notes.**

**Fax completed form to (724) 240-1586**

Phone (724) 510-3702

**1. PATIENT INFORMATION**

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M      F	Weight:	Lbs      Kg
Patient Status:		Next due date (if applicable):	
New to therapy		Continuing therapy	

**2. INSURANCE INFORMATION (required)**

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

**3. PHYSICIAN INFORMATION**

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

**4. DIAGNOSIS INFORMATION (ICD 10 Code Required)**

Chronic Gout ( \_\_\_\_\_ ) **\*Serum Uric Acid (SUA) and G6PD required for referral**      Other: \_\_\_\_\_

**5. PRESCRIPTION INFORMATION (requires new order every 12 months)**

**KRYSTEXXA**

Administer 8mg every 2 weeks IV

Horizon Infusions MD will prescribe and manage Immunomodulation Therapy **\*See below for required labs**

Vital signs per HI Protocol

Anaphylaxis & Hydration Management per HI Protocol

**PRE-MEDICATIONS      N/A**

Acetaminophen      500mg      650mg      1000mg  
 Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)  
 Diphenhydramine (Benadryl)      25mg      50mg      PO      IV (requires driver)  
 Methylprednisolone (Solu-Medrol)      40mg      80mg      125mg IV  
 Prednisone \_\_\_\_\_ mg PO  
 Other \_\_\_\_\_

**POST-MEDICATIONS      N/A**

Acetaminophen      500mg      650mg      1000mg  
 Prednisone \_\_\_\_\_ mg PO  
 Other \_\_\_\_\_

**6. LABS**

<b>CBC w/Diff</b>	Each Infusion	Other Frequency (specify): _____
<b>CMP</b>	Each Infusion	Other Frequency (specify): _____
<b>Hepatitis B</b>	Each Infusion	Other Frequency (specify): _____
<b>Quantiferon TB Gold</b>	Each Infusion	Other Frequency (specify): _____
<b>Folate</b>	Each Infusion	Other Frequency (specify): _____
<b>CRP</b>	Each Infusion	Other Frequency (specify): _____
<b>ESR</b>	Each Infusion	Other Frequency (specify): _____
<b>Hepatic Panel Renal Panel</b>	Each Infusion	Other Frequency (specify): _____
<b>Other (specify):</b>	Each Infusion	Other Frequency (specify): _____

**7. SIGNATURE (required)**

PHYSICIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_